Department of Health & Social Services

Division of Health Care Services

Health Facilities Licensing and Certification

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FY 2004

Application for Initial Designation
& Initial/Renewal of License as a

CRITICAL ACCESS HOSPITAL

The undersigned hereby makes application for designation and license (or renewal of license) to operate a critical access hospital subject to the provisions of AS 18.20.040, and to applicable rules, regulations, and standards adopted under the provisions of the Alaska Administrative Code.

TYPE OF APPLICATION:

☐ INITIAL CRITICAL ACCESS HOSPITAL DESIGNATION AND MEDICARE CERTIFICATION APPLICATION

☐ INITIAL LICENSE OR LICENSE RENEWAL APPLICATION

CURRENT STATUS:

Currently licensed as a:

☐ General Acute Care Hospital? ☐ Rural Primary Care Hospital?

☐ Critical Access Hospital? ☐ *Rural Health Clinic?

☐ Swing Beds? No. of Swing Beds? ☐

*NOTE: At the present time there is no licensure category for Rural Health Clinic.

☐ Facility is NOT-FOR-PROFIT

☐ FACILITY IS PUBLIC OR COMMUNITY OWNED?

☐ NONE OF ABOVE?

1. Identification Information:

   Facility Name: _____

   Address: _____

   City and Zip Code: _____

   Phone Number: _____

   Administrator: _____

   Type of Ownership: _____

   Type of Facility: _____

2. Premises located at: _____
   (Indicate if different from mailing address.)

3. Legal name of individual or organization operating this facility:

   _____

4. If facility is operated on a lease or rental basis, please specify ownership:

   _____

5. Future Expansion: Does your facility plan to add new or delete present services and/or facilities during the next period for which this license is issued?

   ☐ Yes, please specify: _____

   Estimated cost: _____

   Certificate of Need Application Submitted: ____/____/____

   ☐ No

6. Facility has current Malpractice Insurance: ☐ No ☐ Yes (If yes, please fill in below)

COMPANY		
ADDRESS		
EXPIRATION DATE		

7. Application for Licensed Beds:
   Total number being applied for: _____
   Number of designated beds:
   Inpatient Care _____
   Swing Beds _____

8. Patient Statistics:
   a. Facility average daily census: _____
   b. Facility average inpatient stay: _____

9. Please check services offered either directly or through contract or arrangement:

Surgical	☐	Laboratory	☐	Dietary	☐
Anesthesia	☐	Emergency Care	☐	Outpatient	☐
Perinatal	☐	Medical Records	☐	Laundry	☐
Medical	☐	Rehabilitation	☐	Resp Therapy	☐
Nursing	☐	Physical Therapy	☐	Radiology	☐
Pharmacy	☐	Speech Therapy	☐	Psych Therapy	☐
Social Service	☐	Occ. Therapy	☐	Nuclear Medicine	☐
		Activities Therapy	☐		

10. On-site Primary care staff: (Please list full-time equivalents)

____ Physician ____ Physician's Assistant

____ Certified Nurse Practitioner ____ Other - Please specify

_____

_____

_____

_____

_____

_____

11. Direct care staff: (Please list full-time equivalents)

____ RN ____ LPN

____ Nursing Assistant ____ Respiratory Therapy

____ Physical Therapy ____ Occupational Therapy

____ Speech Therapy

12. Does the hospital have any outpatient clinics, either freestanding or in the facility, that are considered a unit (department) of the hospital? (Definition being: outpatient clinic that uses the hospital provider number for Medicare/Medicaid billing):

No:	Yes:	If yes, Location?	Services Provided:
____	____	_____	_____
		_____	_____
		_____	_____
		_____	_____
		_____	_____
		_____	_____
		_____	_____

If yes to #12, are any of the physicians of the outpatient clinics hospital employees? Yes _____ No _____

If yes to #12, please list the physicians in the first column and their specialty in the second column below::

13. List services provided through contract:

14. List names and credentials for the following department heads as they apply:

Medical Staff:		Title:		Lic.	
Dir. of Nursing:		Title:		Lic.	
Social Services:		Title:		Degree	
Dietitian:		Title:		Lic.	
Food Supervisor:		Title:		Degree	
Laboratory:		Title:		Degree	
Rehab Services:		Title:		Degree	
Anesthesiology:		Title:		Lic.	
Infection Control:		Title:		Lic.	
Staff Development:		Title:		Degree	
Pharmacy:		Title:		Lic.	
Quality Assurance:		Title:		Degree	
Outpatient Svcs:		Title:		Degree	
Preventive Maint:		Title:		Degree	
Risk Management:		Title:		Degree	
Activities:		Title:		Degree	

15. What level Emergency Department does the facility currently have, as defined in the Alaska EMS Goals (February 1996)?

☐ Level I Isolated ☐ Level I Highway ☐ Level II Isolated

☐ Level II Highway ☐ Level III ☐ Level IV

☐ Level V

16. Does the facility currently maintain 24 hour staffing in the Emergency Department with a RN, Physician's Assistant, Certified Nurse Practitioner, or Physician?
☐ Yes ☐ No

	Yes	No	
17.	☐	☐	The facility has guidelines for patient teaching.
18.	☐	☐	The facility has a preventive maintenance program, which includes calibration for all patient care and laboratory equipment.
19.	☐	☐	The facility has a comprehensive infection control program, which includes the reporting, and review of all departments.
20.	☐	☐	The facility has guidelines for the transfer of patients to other facilities.
21.	☐	☐	The facility has quality assurance and risk management programs, which include all hospital departments.
22.	☐	☐	The facility has a staff development program which services all hospital departments.
23.	☐	☐	The facility has guidelines for the detoxification process.
24.	☐	☐	The facility is located in a rural area of no more than 10,000 residents based on calculations of the United States Bureau of Census.

25. Does the facility meet ☐, or intend to meet ☐ the requirements for licensure and Medicare certification as a critical access hospital?

26. If the facility does not now meet requirements as a critical access hospital, please indicate date the facility will be in compliance. _____ Please attach explanation.

27. Please indicate in mileage to nearest hospital _____ AIR ☐ HIGHWAY ☐

28. If by highway, please indicate type of road. Primary ☐ Secondary ☐

29. Does the facility agree to limit the average inpatient length of stay to a 96 hours following critical access hospital certification?
☐ YES ☐ NO

30. If this for an initial designation and/or license, has the facility conducted a financial feasibility study? (NOTE: this should be an analysis of the financial impact of CAH conversion.)

☐ YES ☐ NO

31. Please attach copy of results of the financial feasibility study.

32. If this for an initial designation and/or license, has the facility conducted a community needs assessment? (Note: This should be a data driven analysis of availability and utilization of health care services to determine whether CAH is needed.)
☐ YES ☐ NO

33. If this is an application for designation and/or initial licensure for conversion to a critical access hospital, please attach an explanation of how conversion will promote regionalization of rural health services, and improve access to hospital care and other health services in the community you serve.

34. Please attach documentation of methodology and results of the Community Needs Assessment.

35. Has the facility provided public information and education?

36. Please attach documentation and evidence of the provision of public information and education.

RURAL HEALTH NETWORK

37. Is the facility part of a network partnership? ☐ YES ☐ NO

38. Network full service hospital partner facility name

_____

39. Does your facility have network agreements including:

☐ YES ☐ NO Transfer

☐ YES ☐ NO Referral

☐ YES ☐ NO Communications

☐ YES ☐ NO Non-Emergency Patient Transportation

☐ YES ☐ NO Emergency Patient Transportation

40. Please attach copies of signed agreements

41. Does your facility have agreements with at least one hospital that is a member of the network, or with a PRO or equivalent entity, or with another appropriate and qualified entity identified in the State Rural Health Care Plan, including:

☐ YES ☐ NO Medical Staff Credentialing

☐ YES ☐ NO Quality Assurance *(To include evaluation of appropriateness of Diagnosis and treatment)*

42. Please attach copies of signed agreements

43. Does the facility have referral protocols for members of the network?
☐ YES ☐ NO

44. Please attach copy of EMS plan.

45. Does the facility have a description of the services it will provide directly and those, which will be provided through agreement or arrangement by other providers or organizations.
☐ YES ☐ NO

(Please attach copies of agreements/contracts with other providers and organizations for services provided by the facility.)

46 Does the facility have telemedicine capability? Please describe:

47. Does the facility have out-reach services? Please describe:

48. Please attach a separate listing of room numbers, number of beds in each room and their primary use. Additionally, include rooms that are licensed for beds, which are being used for something other than inpatient use and, which can be converted back to inpatient beds within 24 hours.

***NOTE**: The Administrator should be prepared to present Health Facility Licensing and Certification surveyors with a current bed count during the entrance conference of a licensure survey, to include the current use of each room, if other than for patients.*

Signature of Administrator

Date